north dakota department of human services

North Dakota Department of Human Services
Medical Services Division
600 E Boulevard Ave. Dept. 325
Bismarck, ND 58505
701-328-4030 – Fax: 701-328-1544

REQUEST FOR PRE-AUTHORIZATION OF VISION SERVICES

Date: _____ Patient Name: _____

Medicaid ID#: _____ Address: _____

Birth Date: _____ _____

Provider Information

Name/Address: _____ Provider #: _____

_____ Telephone: _____

_____ FAX: _____

Signature: _____ Date: _____

Preauthorization Requested (Circle Applicable):

Other Procedure Exam Refraction Frame Lens: Right Left

Medical Necessity (Required): _____

_____

_____

Appointment Date_____

Date of Previous Eye Exam: _____/_____/_____ Date of Previous Lens: _____/_____/_____ Date of Previous Frame: _____/_____/_____	Present Rx: Sph Cyl Axis OD _____ _____ x _____ OS _____ _____ x _____	Add _____ _____	**Visual Acuity** VA HOTV Prism ____/____ _____ ____/____ _____
	New Rx: Sph Cyl Axis OD _____ _____ x _____ OS _____ _____ x _____	Add _____ _____	**Visual Acuity** VA HOTV Prism ____/____ _____ ____/____ _____

FOR DEPARTMENT USE ONLY

Authorization #: _____

Other Procedure: Approved Denied
Exam/Refraction: Approved Denied
Lens (ES): Approved Denied
Frame: Approved Denied
Signature: _____

Authorized _____

Reason: _____
Reason: _____
Reason: _____
Reason: _____
Date: _____

RETURN THIS FORM TO:

Anthony Mitchell, O.D.
PO Box 1384
Williston, ND 58802-1384
Office Phone and FAX: 701-572-7444
Home Telephone: 701-572-7727